SERFF Tracking Number:	*WAKE-126459799*	*State:*	*Arkansas*
Filing Company:	*The Order of United Commercial Travelers of America*	*State Tracking Number:*	*45063*
Company Tracking Number:	*CMMUCTDVHAR*		
TOI:	*H10I Individual Health - Dental*	*Sub-TOI:*	*H10I.000 Health - Dental*
Product Name:	*DVH Insurance*		
Project Name/Number:	*UCT/CMMUCTDVHAR*		

Filing at a Glance

Company: The Order of United Commercial Travelers of America

Product Name: DVH Insurance	SERFF Tr Num: WAKE-126459799	State: Arkansas
TOI: H10I Individual Health - Dental	SERFF Status: Closed-Approved-Closed	State Tr Num: 45063
Sub-TOI: H10I.000 Health - Dental	Co Tr Num: CMMUCTDVHAR	State Status: Approved-Closed
Filing Type: Form		Reviewer(s): Rosalind Minor
	Authors: Toni Hess, Katlyn Gorman, Steve Keck, Chris Moser	Disposition Date: 03/08/2010
	Date Submitted: 03/02/2010	Disposition Status: Approved-Closed
Implementation Date Requested: On Approval		Implementation Date:

State Filing Description:

General Information

Project Name: UCT	Status of Filing in Domicile: Pending
Project Number: CMMUCTDVHAR	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Individual
Submission Type: New Submission	Group Market Size:
Overall Rate Impact:	Group Market Type:
Filing Status Changed: 03/08/2010	Explanation for Other Group Market Type:
	State Status Changed: 03/08/2010
Deemer Date:	Created By: Chris Moser
Submitted By: Toni Hess	Corresponding Filing Tracking Number:

Filing Description:

RE: The Order of United Commercial Travelers of America
NAIC 56383/ FEIN 31-4273120

SUBMISSION
Dental Vision Hearing Insurance Policy Form Number DVH 0210 AK
Outline of Coverage Form Number DVH OC 0210
Application Form Number DVH APP 0110 AK

SERFF Tracking Number:	*WAKE-126459799*	*State:*	*Arkansas*
Filing Company:	*The Order of United Commercial Travelers of America*	*State Tracking Number:*	*45063*
Company Tracking Number:	*CMMUCTDVHAR*		
TOI:	*H10I Individual Health - Dental*	*Sub-TOI:*	*H10I.000 Health - Dental*
Product Name:	*DVH Insurance*		
Project Name/Number:	*UCT/CMMUCTDVHAR*		

Wakely Actuarial Services, Inc. has been retained by The Order of United Commercial Travelers of America to file the above-captioned forms and rates on their behalf. We are requesting the review and approval of this filing. A letter of authorization is included for reference.

If required, any filing documents have been completed and are included with the filing.

The benefits for dental, vision and hearing are paid after the annual policy deductible is met, by a percentage of actual charges, not to exceed reasonable and customary charges for covered expenses up the policy year maximum benefit. The percentages are based on the number of years of the policy is in force as follows:

Policy Year 1 – 60%
Policy Year 2 – 70%
Policy Year 3 – 80%
Policy Year 4 + - 90%

The amount of $75 is provided for dental cleaning annually after the policy has been in force for three months.

The available annual deductible amounts are $0 and $100. The policy year maximum benefit amounts available are $750, $1,000, $1,500 or $2,000.

This product will by licensed brokers and agents in your state.

Wakely Actuarial Services, Inc. appreciates the Department's time and consideration of this filing for The Order of United Commercial Travelers of America.

Company and Contact

Filing Contact Information

Christopher Moser, Compliance Analyst
931 Clarmont Avenue
Bensalem, PA 19020
Chris.M.Moser@hesscc.com
215-500-4269 [Phone]

Filing Company Information

(This filing was made by a third party - WAS01)

The Order of United Commercial Travelers of CoCode: 56383 State of Domicile: Ohio

SERFF Tracking Number:	*WAKE-126459799*	*State:*	*Arkansas*
Filing Company:	*The Order of United Commercial Travelers of America*	*State Tracking Number:*	*45063*
Company Tracking Number:	*CMMUCTDVHAR*		
TOI:	*H10I Individual Health - Dental*	*Sub-TOI:*	*H10I.000 Health - Dental*
Product Name:	*DVH Insurance*		
Project Name/Number:	*UCT/CMMUCTDVHAR*		

America

1801 Watermark Drive, Suite 100
P.O. Box 159019
COLUMBUS, OH 43215-8619
(800) 848-0123 ext. [Phone]

Group Code: -99
Group Name:
FEIN Number: 31-4273120

Company Type:
State ID Number:

Filing Fees

Fee Required?	Yes
Fee Amount:	$140.00
Retaliatory?	No
Fee Explanation:	Policy - $50 Outline - $20 Application - $20 Rates/ - $50
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
The Order of United Commercial Travelers of America	$140.00	03/02/2010	34534815

SERFF Tracking Number:	*WAKE-126459799*	*State:*	*Arkansas*
Filing Company:	*The Order of United Commercial Travelers of America*	*State Tracking Number:*	*45063*
Company Tracking Number:	*CMMUCTDVHAR*		
TOI:	*H10I Individual Health - Dental*	*Sub-TOI:*	*H10I.000 Health - Dental*
Product Name:	*DVH Insurance*		
Project Name/Number:	*UCT/CMMUCTDVHAR*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	03/08/2010	03/08/2010

Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	**Created By**	**Created On**	**Date Submitted**	**Responded By**	**Created On**	**Date Submitted**
Pending Industry Response	Rosalind Minor	03/04/2010	03/04/2010			

Amendments

Schedule	Schedule Item Name	Created By	Created On	Date Submitted
Form	Dental Vision and Hearing Policy	Chris Moser	03/05/2010	03/05/2010
Form	Outline of Coverage	Chris Moser	03/05/2010	03/05/2010
Rate	DVH AJ Rates	Chris Moser	03/05/2010	03/05/2010
Supporting Document	Health - Actuarial Justification	Chris Moser	03/05/2010	03/05/2010

SERFF Tracking Number:	*WAKE-126459799*	*State:*	*Arkansas*
Filing Company:	*The Order of United Commercial Travelers of America*	*State Tracking Number:*	*45063*
Company Tracking Number:	*CMMUCTDVHAR*		
TOI:	*H10I Individual Health - Dental*	*Sub-TOI:*	*H10I.000 Health - Dental*
Product Name:	*DVH Insurance*		
Project Name/Number:	*UCT/CMMUCTDVHAR*		

Disposition

Disposition Date: 03/08/2010
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*WAKE-126459799*	*State:*	*Arkansas*
Filing Company:	*The Order of United Commercial Travelers of America*	*State Tracking Number:*	*45063*
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Product Name:	*DVH Insurance*		
Project Name/Number:	*UCT/CMMUCTDVHAR*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document *(revised)*	Health - Actuarial Justification	Approved-Closed	No
Supporting Document	Health - Actuarial Justification	Replaced	No
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Supporting Document	Letter of Authorization	Approved-Closed	Yes
Form *(revised)*	Dental Vision and Hearing Policy	Approved-Closed	Yes
Form	Dental Vision and Hearing Policy	Replaced	Yes
Form	Application	Approved-Closed	Yes
Form *(revised)*	Outline of Coverage	Approved-Closed	Yes
Form	Outline of Coverage	Replaced	Yes
Rate	DVH AJ Rates	Approved-Closed	Yes

SERFF Tracking Number:	*WAKE-126459799*	*State:*	*Arkansas*
Filing Company:	*The Order of United Commercial Travelers of America*	*State Tracking Number:*	*45063*
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TOI:	*H10I Individual Health - Dental*	*Sub-TOI:*	*H10I.000 Health - Dental*
Product Name:	*DVH Insurance*		
Project Name/Number:	*UCT/CMMUCTDVHAR*		

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	03/04/2010
Submitted Date	03/04/2010
Respond By Date	

Dear Christopher Moser,

This will acknowledge receipt of the captioned filing.

Objection 1

- Dental Vision and Hearing Policy, DVH 0210 (Form)
- Outline of Coverage, DVH OC 0210 (Form)

Comment:

The policy and the outline states that...."After the Policy Year Deductible is satisfied, the company will pay the following percentages of actual charges, not to exceed Reasonable and Customary Charges for Covered Expenses....".

We have had problems in the past, with several insurance companies, with the use of the term, we will pay the percentage of actual charges when in fact you will pay the percentages not to exceed R&C Charges for covered expenses.

It is requested that you delete reference to paying the percentage of actual charges.

Thank you for your understanding and cooperation in this matter.

Please feel free to contact me if you have questions.
Sincerely,
Rosalind Minor

SERFF Tracking Number:	*WAKE-126459799*	*State:*	*Arkansas*
Filing Company:	*The Order of United Commercial Travelers of America*	*State Tracking Number:*	*45063*
Company Tracking Number:	*CMMUCTDVHAR*		
TOI:	*H10I Individual Health - Dental*	*Sub-TOI:*	*H10I.000 Health - Dental*
Product Name:	*DVH Insurance*		
Project Name/Number:	*UCT/CMMUCTDVHAR*		

Amendment Letter

Submitted Date: 03/05/2010

Comments:

The corrections noted in the objection have been made. Also there was a mistake on the rate page refering to the Form number affected. This has been changed and is also included.

Changed Items:

Form Schedule Item Changes:

Form Schedule Item Changes:

Form Number	Form Type	Form Name	Action	Form Action Other	Previous Filing #	Replaced Form #	Readability Score	Attachments
DVH 0210 AR	Policy/Contract/Fraternal Certificate	Dental Vision and Hearing Policy	Initial				41.400	DVH 0210 AR.pdf
DVH OC 0210 AR	Outline of Coverage	Outline of Coverage	Initial				43.400	DVH OC 0210 AR.pdf

Rate/Rule Schedule Item Changes:

Document Name:	Affected Form Numbers: (Comma Separated list)	Rate Action:	Rate Action Information:	Attach Document:
DVH AJ Rates	DVH 0210 AR	New		DVH AJ Rates.pdf
DVH AJ Rates.pdf				

Supporting Document Schedule Item Changes:

Satisfied -Name: Health - Actuarial Justification

Comment:

DVH AJ Rev 03052010.pdf

SERFF Tracking Number:	*WAKE-126459799*	*State:*	*Arkansas*
Filing Company:	*The Order of United Commercial Travelers of America*	*State Tracking Number:*	*45063*
Company Tracking Number:	*CMMUCTDVHAR*		
TOI:	*H10I Individual Health - Dental*	*Sub-TOI:*	*H10I.000 Health - Dental*
Product Name:	*DVH Insurance*		
Project Name/Number:	*UCT/CMMUCTDVHAR*		

Form Schedule

Lead Form Number: DVH 0110

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 03/08/2010	DVH 0210 AR	Policy/Contract/Fraternal Certificate	Dental Vision and Hearing Policy	Initial		41.400	DVH 0210 AR.pdf
Approved-Closed 03/08/2010	DVH APP 0110 AR	Application/Enrollment Form	Application	Initial		40.800	DVH APP 0110 AR.pdf
Approved-Closed 03/08/2010	DVH OC 0210 AR	Outline of Coverage	Outline of Coverage	Initial		43.400	DVH OC 0210 AR.pdf

THE ORDER OF
UNITED COMMERCIAL TRAVELERS OF AMERICA

1801 WATERMARK DRIVE, SUITE 100, P.O. BOX 159019, COLUMBUS, OH 43215-8619
(614) 487-9680 • TOLL-FREE: (800) 848-0123 • FAX: (614) 487-9675 • www.uct.org

DENTAL, VISION AND HEARING EXPENSE INSURANCE POLICY

THIS IS A LIMITED BENEFIT POLICY WHICH ONLY PROVIDES BENEFITS FOR DENTAL, VISION AND HEARING EXPENSES. IT DOES NOT PROVIDE BENEFITS FOR ANY OTHER SICKNESS, CONDITION OR INCAPACITY. THIS POLICY WILL NOT COVER ALL OF YOUR MEDICAL EXPENSES.

THIS IS A LEGAL CONTRACT BETWEEN THE OWNER AND US.

This is a contract between You and The Order of United Commercial Travelers of America (UCT). We issue this Policy based on the application signed by You and the payment of premiums as stated on the Policy Schedule Page. We will pay the benefits subject to all the terms and conditions of this Policy. This Policy begins on the Date of Issue listed on the Policy Schedule Page. Payment of each premium as it comes due will continue coverage to the next premium due date.

The Order of United Commercial Travelers of America will pay the benefits of this Policy for an Insured Loss subject to the provisions and limitations of the Policy.

IMPORTANT NOTICE: The issuance of this Policy is based on the Insured's answers to the questions on the application. A copy of the application is attached. Omissions or misstatements on the application could cause a claim to be denied or the Policy to be rescinded. If, for any reason the answers are incorrect, contact Us immediately at Our Home Office in Columbus, Ohio.

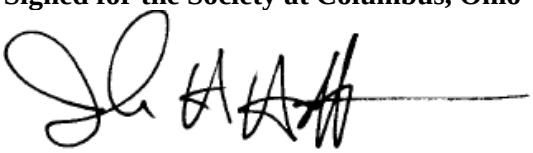
Thirty Day Right To Examine and Return Policy

Please read this Policy carefully. If, for any reason You are not satisfied, the Policy may be returned to Us within thirty (30) days after receiving it. If returned, the Policy will be void from its beginning and any premium paid will be refunded.

Guaranteed Renewable for Life - Premium Subject to Change

This Policy is renewable as long as You live, provided You continue to pay premiums when due. At no time while You continue Your Policy in force, may We place any restrictive riders on Your coverage. The premium may change if a new table of rates is applicable to the Policy. The change in the table of rates will apply to all covered persons in the same class on the date of the change. Class is defined as underwriting class, state and zip code of residence. You will be notified at least thirty (30) days prior to any change in the table of rates becoming effective.

Signed for the Society at Columbus, Ohio



Chief Executive Officer

NOTICE TO BUYER: This is NOT a Medicare Supplement Policy. If You are eligible for Medicare, review the Medicare Supplement Buyer's Guide available from Us.

NON-PARTICIPATING

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Guaranteed Renewable for Life - Premium Subject to Change 1

Notice To Buyer 1

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Application ..... **Attached**

POLICY SCHEDULE PAGE

Policy Number: **[12345678]** **Policy Effective Date:** **[July 1, 2010]**

Policyholder Name: **[John Doe]** **Issue Age:** **[45]**

Mode At Issue: **Modal Premium:**

****

Policy Year Deductible: **[$0 or $100]**

Policy Year Maximum Benefit: **[$750, $1,000, $1,500 or $2,000]**

Definitions

Audiologist refers to a person duly licensed and legally entitled to practice audiology at the time and in the state or jurisdiction in which services are performed, other than a member of the Insured's Immediate Family.

Covered Expense or Covered Loss refers to expenses incurred for Medically Necessary medical and dental services or supplies prescribed by a licensed medical professional. Covered Expenses may not be more than the Reasonable and Customary Charges for such services or supplies and will be deemed to be incurred on the date or dates such services or supplies are received by the Insured. Covered Expenses must be incurred while this Policy is in force.

Dentist refers to a person duly licensed and legally entitled to practice dentistry at the time and in the state or jurisdiction in which services are performed, other than a member of the Insured's Immediate Family.

Experimental or Investigational Procedure or Treatment refers to the use of a treatment (drugs, devices and/or procedures) for a specific condition when all of the following are true:

1. the safety and effectiveness of a device is not proven; i.e. pre-market approval has not been granted (devices only);
2. benefits to at least one-third (1/3) of subjects are not documented in controlled clinical trials published in peer-reviewed English language medical journals; and
3. the treatment is not generally accepted medical practice as determined by review of peer-reviewed English language medical literature or authoritative medical journals or publications.

Immediate Family means Your spouse; parents; grandparents; children; or siblings and their spouses.

Injury means a bodily Injury which is the direct result of an accident and independent of all other causes that occurs after the Policy Effective Date and while this Policy is in force.

Insured refers to the person who is insured under this Policy. The Insured is as named in the application and shown on the Policy Schedule Page.

Medically Necessary means a service or supply that is required to diagnose or treat an Injury or Sickness and is:

1. prescribed by a Physician or other licensed medical professional;
2. consistent with the diagnosis and treatment of the Injury or Sickness;
3. in accordance with the generally accepted standards of medical practice; and
4. not solely for the convenience of You or the Physician or other licensed medical professional.

Ophthalmologist is a Physician duly licensed and legally entitled to practice ophthalmology at the time and in the state or jurisdiction in which services are performed, other than a member of the Insured's Immediate Family.

Optometrist is a Physician duly licensed and legally entitled to practice optometry at the time and in the state or jurisdiction in which services were performed, other than a member of the Insured's Immediate Family.

Physician means any practitioner of the healing arts acting within the scope of his/her license, other than a member of the Insured's Immediate Family.

Policy Effective Date is the effective date of this Policy and is as shown on the Policy Schedule Page. The Policy Effective Date is not the date the application for coverage was signed.

Policy Year is a period of twelve months beginning each year on the month and day of the Policy Effective Date.

Policy Year Deductible refers to the dollar amount for which You are responsible during each Policy Year as shown on the Policy Schedule Page.

Definitions Continued

Policy Year Maximum Benefit is the maximum amount We will pay during any Policy Year as shown on the Policy Schedule Page.

Pre-Existing Condition means a condition for which symptoms existed prior to the Policy Effective Date that would cause an ordinarily prudent person to seek diagnosis, care or treatment or for which medical advice or treatment was recommended by a Physician or received from a Physician.

Reasonable and Customary Charge refers to the normal and prevailing charge, fee, or expense for the service rendered or for the material furnished in the geographic area where rendered or furnished.

Sickness means illness or disease with first manifests itself after the Policy Effective Date and while this Policy is in force.

Written Notice to the Company means a request in writing on forms furnished by or acceptable to the Company. All correspondence should be sent to Our Home Office at P.O. Box 159019, Columbus, Ohio 43215.

We, Our, Us, Society, Company, UCT means The Order of United Commercial Travelers of America.

You, Your, Yours means the Insured named on the Policy Schedule Page.

Benefit Provisions

After the Policy Year Deductible is satisfied, the Company will pay the following percentages, not to exceed Reasonable and Customary Charges for Covered Expenses up to the Policy Year Maximum Benefit:

1. 60% in the first Policy Year;
2. 70% in the second Policy Year;
3. 80% in the third Policy Year; and
4. 90% thereafter.

Covered Expenses, subject to the Limitations and Exclusions, are:

Dental Benefits
We will pay the applicable percentage for dental services performed by a licensed Dentist, including one annual examination and cleaning, x-rays, fillings, prophylaxis, bridges, crowns, dentures and outpatient dental surgery prescribed as Medically Necessary.

After the Policy has been in force three (3) months, the Company will pay the cost of one (1) dental cleaning up to a maximum benefit of $75 each Policy Year. This benefit is not subject to the Policy Year Deductible; however, it is included in the Policy Year Maximum Benefit.

We will NOT pay any benefits during the first six (6) months following the Policy Effective Date for root canals.

We will NOT pay benefits during the first Policy Year for the following items and/or services:
Bridges, crowns, full dentures or partials, any work relating to replacement of natural teeth which were missing on the Policy Effective Date, “full mouth” extractions or fluoride treatments;

Hearing Benefits
We will pay the applicable percentage for hearing examinations performed by a Physician or Audiologist, including the cost of the hearing aid and any necessary repairs.

We will NOT pay benefits during the first Policy Year for existing hearing aids.

Benefit Provisions Continued

Vision Benefits
We will pay the applicable percentage for visits to a Physician for a basic eye examination or eye refraction, including the cost of eyeglasses or contact lenses prescribed by the Physician, up to a maximum benefit of $150 in any one (1) Policy Year.

We will NOT pay any benefits during the first six (6) months following the Policy Effective Date for existing eyeglasses or contact lens (including the renewal or changing of prescriptions).

Limitations and Exclusions

This Policy has a Policy Year Deductible as shown on the Policy Schedule Page. Once the Policy Year Deductible has been met, benefits are limited to the Policy Year Maximum Benefit as shown on the Policy Schedule Page.

We will NOT pay benefits for:

1. any loss resulting from war, declared or undeclared; or
2. any intentionally self-inflicted Injury; or
3. any loss resulting from the commission of or the attempt to commit an assault or felony; or
4. any loss resulting from engaging in any illegal activity or occupation; or
5. any services that are not recommended by a Physician or other licensed medical professional; or
6. any Experimental or Investigational Procedure or Treatment; or
7. orthodontic treatment; or
8. any expenses incurred for the diagnosis or treatment of temporomandibular joint disorder (TMJ); or
9. expenses incurred for surgical procedures (other than outpatient dental surgery) performed on an inpatient or outpatient basis (including any surgical procedure performed for the treatment of cataracts); or
10. charges for radial keratotomy (RK), automated lamellar keratoplasty (ALK), conductive keratoplasty (CK) or other cosmetic procedures; or
11. prescription drugs; or
12. charges in excess of Reasonable and Customary Charges; or
13. treatment or diagnosis received while outside the United States of America or its territories; or
14. services for which you are not liable or for which no charge normally is made in the absence of insurance; or
15. loss that occurs while this Policy is not in force.

General Provisions

Entire Contract; Changes – This Policy, including the application, endorsements and attached documents, if any, constitutes the entire contract of insurance. No change in this Policy shall be valid unless approved by one of the Company's officers and unless such approval shall be endorsed hereon or attached hereto. No agent or officer of any Local, Grand or Supreme Council has authority to change this Policy or to waive any of its provisions.

Time Limit On Certain Defenses (Contestable Period) – Statements in the application are considered representations, not warranties. Statements may be used to contest the validity of this Policy or in defense of a claim only if they are contained in an attached application or endorsement. The Company cannot contest this Policy after it has been in force two years during the Insured's lifetime, from the Policy Effective Date.

Grace Period – A Grace Period of thirty-one (31) days will be granted for the payment of each premium falling due after the first premium. This Policy shall continue in force during any Grace Period.

Reinstatement – If any renewal premium is not paid within the time granted by Us for payment, a subsequent acceptance of any premium by Us or by any of Our authorized agents, without requiring an application for reinstatement, shall reinstate the Policy; provided, however that, if We or any of Our authorized agents require an application for reinstatement and issues a conditional receipt for the premium tendered, the Policy will be reinstated upon approval of such application by Us or, lacking such approval, upon the forty-fifth (45) day following the date of such conditional receipt unless We have previously notified You in writing of Our disapproval of such application. The reinstated Policy shall cover only loss resulting from any accidental Injury as may be sustained after the date of reinstatement and loss due to any Sickness as may begin more than ten (10) days after that date. In all other respects, We and You shall have the same rights there under as We and You had under the Policy immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with reinstatement.

Notice of Claim – We must receive written Notice of Claim within twenty (20) days after any Covered Loss occurs or begins. If notice cannot be given at that time, it must be given as soon as reasonably possible. Notice given by or on Your behalf to the Society at Our Home Office at 1801 Watermark Drive, Suite 100, P.O. Box 159019, Columbus, Ohio 43215-8619, or to any authorized agent of Us, with information sufficient to identify You, shall be deemed notice to Us.

Claim Forms – When We get a Notice of Claim, We will send You forms for filing Proof of Loss. If We do not send the forms within fifteen (15) working days after receiving Written Notice, Our requirements will be met if We receive written proof of the event and type and extent of the loss within ninety (90) days after the date the loss began or occurred.

Proof of Loss – We must receive written Proof of Loss within ninety (90) days after the date the loss began or occurred. If it is not reasonably possible to give this timely proof, the claim will not be affected if it is sent as soon as is reasonable. However, unless the Insured making the claim is legally incapacitated, proof must be given within one (1) year from the time it is otherwise due.

Time of Payment of Claims – All benefits payable under this Policy will be payable immediately upon receipt of due Proof of Loss.

If We do not pay benefits upon receipt of due Proof of Loss, We shall have fifteen (15) working days to mail to You a letter or notice which states the reasons We have for not paying the claim, either in whole or in part, including an itemization of any documents or other information needed to process the claim or any portions thereof which have not been paid. Once all of the listed documents or other information needed to process the claim have been received, We shall then have fifteen (15) working days to process and either pay the claim or deny it, in whole or in part, giving You the reasons We may have for denying such claim or any portion thereof.

Payment of Claims – We will pay all benefits to You; benefits under this Policy are not subject to assignment. Any benefits unpaid at Your death will be paid to Your estate or Your designated beneficiary.

Legal Actions – No action at law or in equity shall be brought to recover on this Policy prior to the expiration of sixty (60) days after written Proof of Loss has been furnished in accordance with the requirements of this Policy. No such action shall be brought after the expiration of three (3) years after the time written Proof of Loss is required to be furnished.

Misstatement Of Age or Sex – If the Insured's age or sex has been misstated, all amounts payable under this Policy shall be such as the premium paid would have purchased at the correct age and sex.

Unpaid Premium: Upon the payment of a claim under this Policy, any premium then due and unpaid or covered by any note or written order may be deducted therefrom.

Pro Rata Refund: If We receive written proof of death which terminates coverage, We will refund that part of any premium You have paid which covers a period after death occurs.

Cancellation By Insured – You may cancel this Policy at any time by Written Notice to the Company delivered or mailed to Us. Cancellation will be effective upon receipt of the Written Notice or on a later date as specified in the notice. In the event of cancellation of this Policy, We shall make a pro-rata refund of any premium paid beyond the date of cancellation. Cancellation shall be without prejudice to any claim originating prior to the date of the cancellation.

Insurance coverage will terminate automatically as of the premium due date if premium for this Policy is in default beyond the end of the Grace Period.

Conformity With State Statute – Any provision of the Policy which, on the Policy Effective Date, is in conflict with the laws of the state in which the Insured resides on such date is hereby amended to conform to the minimum requirements of such statutes.

Clerical Error – Clerical error on Our part will not invalidate insurance otherwise in force nor continue insurance otherwise terminated. Upon discovery of any error, an equitable adjustment will be made in the premiums. Complete proof documenting any clerical errors must be supplied.

Owner – The Insured is the Owner of this Policy and may exercise all options and rights under this Policy.

Maintenance of Solvency – UCT's constitution provides that in the event that its reserves as to all or any class of contracts of insurance issued by it become impaired, the Board of Governors may require that these shall be paid by each Owner of such contract of insurance to UCT an amount equal to such Owner's equitable portion of such deficiency as ascertained by the Board of Governors.

If payment of the amount required is not made by such Owner, then either or both of the following, at the election of the Owner, shall apply:

1. the amount shall stand as Indebtedness against the contract of insurance and shall bear interest at a rate not to exceed ten percent (10%) per annum; or
2. the Owner shall accept a proportionate reduction in benefits paid pursuant to the contract of insurance.

The Owner shall make such election by notifying the Board of Governors of his or her election on a form prescribed by the Board of Governors that shall be provided to each Owner. Failure to make such election shall result in a presumption that the Owner elects to accept a proportionate reduction in benefits paid pursuant to the contract of insurance.

The Owner hereby agrees that if they affirmatively elect to have the amount stand as Indebtedness against the contract of insurance, then UCT may offset the amount of such Indebtedness together with interest thereon against any payment of benefits under this contract of insurance.

Suspension or Expulsion – If the Insured should be expelled or suspended from the membership in the Society for any reason, except nonpayment of premium or within the Contestable Period for misrepresentation on the Insured's application for membership, the Insured shall have the privilege of maintaining this Policy in force by continuing payment of the required premium.

DENTAL, VISION AND HEARING EXPENSE POLICY
A LIMITED BENEFIT INSURANCE POLICY

NON-PARTICIPATING

The Order of UNITED COMMERCIAL TRAVELERS OF AMERICA
Home Office: 1801 Watermark Drive, Suite 100, P.O. Box 159019, Columbus, Ohio 43215-8619
(614) 487-9680, Toll-free: (800) 848-0123, Fax: (614) 487-9675 www.uct.org

APPLICATION FOR DENTAL, VISION AND HEARING INSURANCE POLICY

Requested Effective Date of Policy

APPLICANT

Last *First* *MI*

AGE	DATE OF BIRTH			SEX
	Month	*Day*	*Year*	☐ Male ☐ Female

SOCIAL SECURITY NUMBER

APPLICANT'S ADDRESS

Street: _____

_____

_____

City: _____

State: _____ *Zip Code:* _____

Area Code: _____ *Telephone Number:* _____

*Email Address:*_____

Are you a member of The Order of United Commercial Travelers of America? ☐ **Yes** ☐ **No**

Council Name:_____ **Council Location (City & State)** _____

PLEASE SELECT THE METHOD OF PAYMENT YOU WANT

☐ Annual ☐ Semi-Annual ☐ Quarterly ☐ Monthly EFT

Amount Received with Application $_____

MEDICAL INFORMATION

		APPLICANT	
1.	Do you currently wear dentures?	☐ Yes	☐ No
2.	Have you been advised to have any dental work which has not been completed? If "Yes", provide details: _____	☐ Yes	☐ No
3.	Do you currently wear eyeglasses or contact lens?	☐ Yes	☐ No
4.	Have you received advice or treatment within the past nine (9) months for correction of a vision problem? If "Yes", provide details: _____	☐ Yes	☐ No
5.	Do you currently wear a hearing aid?	☐ Yes	☐ No
6.	Have you been treated for hearing loss within the past nine (9) months?	☐ Yes	☐ No
7.	Has a physician recommended the purchase of a hearing aid to correct a hearing deficiency?	☐ Yes	☐ No

BENEFIT OPTIONS

Policy Year Maximum	☐ **$750**	☐ **$1,000**	☐ **$1,500**	☐ **$2,000**
Deductible Options	☐ **$0**		☐ **$100**	

REPLACEMENT INFORMATION (MUST BE COMPLETED)

		APPLICANT	
1.	Do you have any dental, vision or hearing insurance currently in force?	☐ Yes	☐ No
2.	Is the insurance applied for intended to replace any existing insurance with this or any other company?	☐ Yes	☐ No

If "Yes", with which company: (Name and address): _____

_____

Policy Number: _____ If that policy lapsed, when did it lapse? _____

3. If replacement is involved, have you received a replacement form (in states where required by law)? ☐ Yes ☐ No

AUTHORIZATION
MUST BE COMPLETED AND SIGNED

WARNING: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for Insurance is guilty of a crime and may be subject to fines and confinement in prison.

_____ _____

Signature of Applicant **Date**

REASON FOR DISCLOSURE

I understand that the information requested is necessary for evaluation of my application and underwriting of my application for the Insurance Policy for which I have applied; to determine eligibility for insurance, risk rating or policy issuance determinations; obtain reinsurance, administer claims and determine or fulfill responsibility for coverage and provision of benefits; and to conduct other legally permissible activities that relate to any coverage I have, or have applied for, with The Order of United Commercial Travelers of America (UCT). I understand that failure to provide the authorization to The Order of United Commercial Travelers of America (UCT) *will* result in the rejection of the Insurance Policy coverage. I understand that I may revoke this authorization at any time by notifying The Order of United Commercial Travelers of America (UCT) in writing at their Home Office: 1801 Watermark Drive, Suite 100, P.O. Box 159019, Columbus, Ohio 43215-8619. I understand that such revocation will not have any effect on actions The Order of United Commercial Travelers of America (UCT) took prior to their receiving the revocation notice. I understand that this authorization will be valid for twenty-four (24) months from the date signed if used in connection with an application for an insurance policy, reinstatement of an insurance policy, change in policy benefits; or for the duration of a claim if used for the purpose of collecting information with a claim for benefits under the policy. A photocopy of this authorization will be treated in the same manner as the original.

_____ _____

Signature of Applicant **Date**

APPLICATION AGREEMENT

I hereby apply to The Order of United Commercial Travelers of America (UCT) for a policy to be issued in reliance on my written answers to the questions on this application. The answers are, to the best of my knowledge and belief, true. I understand that any change in my health prior to delivery of this policy may be used in the underwriting evaluation process. I have received an outline of coverage for the policy applied for.

If not a current member of The Order of United Commercial Travelers of America, I apply to become a member as indicated by my signature below. I understand UCT is a fraternal benefit society and agree to abide by the Society's Constitution and Bylaws.

_____ _____

Signature of Applicant **Date**

AGENT'S CERTIFICATION

The undersigned Agent certifies that the Applicant has read, or has had read to them, the completed application and that the Applicant realizes that any false statement or misrepresentation in the application may result in loss of coverage under the policy.

TO BE COMPLETED BY AGENT (Attach separate sheet, if necessary)

1. List any other health insurance policy you have sold to the Applicant that is still in force.

_____
_____
_____
_____

2. List any other health insurance policy you have sold to the Applicant in the past five (5) years that is no longer in force.

_____
_____
_____
_____

I certify that:

1. I have accurately recorded the information supplied by the Applicant; and
2. I have given an outline of coverage for the policy applied for to the Applicant.

Agent's Signature	**Date**
Agent's Printed Name	**Agent No.**
Agent Email:	

AUTHORITY TO HONOR PREMIUM CHECKS - ATTACH VOIDED CHECK
Deposit Slips NOT Accepted

AUTHORIZATION

IN FAVOR OF: **The Order of United Commercial Travelers of America**
1801 Watermark Drive, Suite 100, Box 159019, Columbus, Ohio 43215-8619.

Name of Bank Customer:

Insured's Name: _____

Account Number: _____ **Routing Number:** _____

To (Name of Bank): _____
Address of Bank:

You are hereby authorized, as a convenience to me, to honor and charge my account for checks, drafts and other orders, including without limitation any order initiated by electronic means, drawn by The Order of United Commercial Travelers of America indicated above, on my account by and payable to the order of The Order of United Commercial Travelers of America for the payment of premiums provided there are sufficient collected funds in such account to pay the same upon presentation. I agree that your rights in respect to each such check or other order drawn by The Order of United Commercial Travelers of America shall be the same as if it were a check drawn on you and signed personally by me. This authority is to remain in effect until revoked by me in writing, and until you actually receive such notice I agree that you shall be fully protected in honoring any such check or other orders drawn by The Order of United Commercial Travelers of America. I further agree that if any such checks or other orders drawn by The Order of United Commercial Travelers of America be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in forfeiture of insurance.

Date	**Signature of Bank Customer**

AUTHORIZATION

Signature must be the same as on the signature card at bank, and if a company account the name of the account must be shown.

To: Bank above:

In consideration of your compliance with the individual authorization of your depositors to pay checks, drafts or orders, drawn and signed by us to our Order, we agree:

- To indemnify you and hold you harmless from any loss you may suffer as a consequence of your actions resulting from or in connection with the execution and issuance of any check, draft or order, whether or not genuine, purporting to be executed and received by you in the regular course of business for the purpose of payment of such insurance premiums including any costs or expenses reasonably incurred in connection therewith.
- In the event that any such check, draft or order shall be dishonored, whether with or without cause, and whether intentionally or inadvertently, to indemnify you for such loss even though dishonor results in forfeiture of the insurance.
- To defend at our own cost and expense any action which might be brought by any depositor or any other persons because of your actions taken pursuant to said authorization and direction or in any manner arising by reason of your participation in this plan of premium collection.

THE ORDER OF
UNITED COMMERCIAL TRAVELERS OF AMERICA
1801 WATERMARK DRIVE, SUITE 100, P.O. BOX 159019, COLUMBUS, OH 43215-8619
(614) 487-9680 • TOLL-FREE: (800) 848-0123 • FAX: (614) 487-9675 • www.uct.org

DENTAL, VISION AND HEARING EXPENSE INSURANCE POLICY

THIS IS A LIMITED BENEFIT POLICY WHICH ONLY PROVIDES BENEFITS FOR DENTAL, VISION AND HEARING EXPENSES. IT DOES NOT PROVIDE BENEFITS FOR ANY OTHER SICKNESS, CONDITION OR INCAPACITY. THIS POLICY WILL NOT COVER ALL OF YOUR MEDICAL EXPENSES.

OUTLINE OF COVERAGE POLICY FORM DVH 0210

THE POLICY IS NOT A MEDICARE SUPPLEMENT POLICY. If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from the Company.

READ YOUR POLICY CAREFULLY. This outline of coverage provides a very brief description of some of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth, in detail, the rights and obligations of both you and United Commercial Travelers of America. It is therefore important that you **READ YOUR POLICY CAREFULLY.**

Dental, Vision and Hearing only coverage is designed to provide you with coverage for certain losses for dental, vision and hearing **ONLY**, subject to any limitations contained in the policy. Coverage is not provided for basic hospital, basic medical-surgical, or major medical expenses.

BENEFITS. After the Policy Year Deductible is satisfied, the following percentages, not to exceed Reasonable and Customary Charges for Covered Expenses up to the Policy Year Maximum Benefit:

1. 60% in the first Policy Year;
2. 70% in the second Policy Year;
3. 80% in the third Policy Year; and
4. 90% thereafter.

Covered Expenses, subject to the Limitations and Exclusions, are:

Dental Benefits
We will pay the applicable percentage for dental services performed by a licensed Dentist, including one annual examination and cleaning, x-rays, fillings, prophylaxis, bridges, crowns, dentures and outpatient dental surgery prescribed as Medically Necessary.

After the Policy has been in force three (3) months, the Company will pay the cost of one (1) dental cleaning up to a maximum benefit of $75 each Policy Year. This benefit is not subject to the Policy Year Deductible; however, it is included in the Policy Year Maximum Benefit.

We will NOT pay any benefits during the first six (6) months following the Policy Effective Date for root canals.

We will NOT pay benefits during the first Policy Year for the following items and/or services:
Bridges, crowns, full dentures or partials, any work relating to replacement of natural teeth which were missing on the Policy Effective Date, “full mouth” extractions or fluoride treatments;

Hearing Benefits
We will pay the applicable percentage for hearing examinations performed by a Physician or Audiologist, including the cost of the hearing aid and any necessary repairs.

We will NOT pay benefits during the first Policy Year for existing hearing aids.

Vision Benefits
We will pay the applicable percentage for visits to a Physician for a basic eye examination or eye refraction, including the cost of eyeglasses or contact lenses prescribed by the Physician, up to a maximum benefit of $150 in any one (1) Policy Year.

We will NOT pay any benefits during the first six (6) months following the Policy Effective Date for existing eyeglasses or contact lens (including the renewal or changing of prescriptions).

Limitations and Exclusions

This Policy has a Policy Year Deductible as shown on the Policy Schedule Page. Once the Policy Year Deductible has been met, benefits are limited to the Policy Year Maximum Benefit as shown on the Policy Schedule Page.

We will NOT pay benefits for:

1. any loss resulting from war, declared or undeclared; or
2. any intentionally self-inflicted Injury; or
3. any loss resulting from the commission of or the attempt to commit an assault or felony; or
4. any loss resulting from engaging in any illegal activity or occupation; or
5. any services that are not recommended by a Physician or other licensed medical professional; or
6. any Experimental or Investigational Procedure or Treatment; or
7. orthodontic treatment; or
8. any expenses incurred for the diagnosis or treatment of temporomandibular joint disorder (TMJ); or
9. expenses incurred for surgical procedures (other than outpatient dental surgery) performed on an inpatient or outpatient basis (including any surgical procedure performed for the treatment of cataracts); or
10. charges for radial keratotomy (RK), automated lamellar keratoplasty (ALK), conductive keratoplasty (CK) or other cosmetic procedures; or
11. prescription drugs; or
12. charges in excess of Reasonable and Customary Charges; or
13. treatment or diagnosis received while outside the United States of America or its territories; or
14. services for which you are not liable or for which no charge normally is made in the absence of insurance; or
15. loss that occurs while this Policy is not in force.

RENEWABILITY. The policy is guaranteed renewable for life. We will renew the policy each time you send us a premium. It must be paid on or before the date it is due or during the 31 days that follow.

PREMIUM CHANGE. We may change the premium rates for the policy. The change will be based on a new table of rates. We can only change the premium if we change it for all policies like yours in your class and in the same state where your policy was issued.

SERFF Tracking Number:	*WAKE-126459799*	*State:*	*Arkansas*
Filing Company:	*The Order of United Commercial Travelers of America*	*State Tracking Number:*	*45063*
Company Tracking Number:	*CMMUCTDVHAR*		
TOI:	*H10I Individual Health - Dental*	*Sub-TOI:*	*H10I.000 Health - Dental*
Product Name:	*DVH Insurance*		
Project Name/Number:	*UCT/CMMUCTDVHAR*		

Rate/Rule Schedule

Schedule Item Status:	Document Name:	Affected Form Numbers: (Separated with commas)	Rate Action:*	Rate Action Information:	Attachments
Approved-Closed 03/08/2010	DVH AJ Rates	DVH 0210 AR	New		DVH AJ Rates.pdf

THE ORDER OF UNITED COMMERCIAL TRAVELERS OF AMERICA
Dental,Vision and Hearing Product - Form DVH 0210
Exhibit B - Gross Premiums

Annual Premium Rates

	$750 Annual Max	
	$0	$100
Issue Age	Deductible	Deductible
18-39	340.00	298.00
40-59	367.00	322.00
60-74	408.00	358.00
75-79	435.00	382.00
80-84	463.00	406.00

	$1,000 Annual Max	
	$0	$100
Issue Age	Deductible	Deductible
18-39	378.00	332.00
40-59	408.00	358.00
60-74	454.00	398.00
75-79	484.00	425.00
80-84	514.00	451.00

	$1,500 Annual Max	
	$0	$100
Issue Age	Deductible	Deductible
18-39	490.00	430.00
40-59	533.00	468.00
60-74	582.00	511.00
75-79	606.00	532.00
80-84	630.00	553.00

	$2,000 Annual Max	
	$0	$100
Issue Age	Deductible	Deductible
18-39	559.00	491.00
40-59	601.00	527.00
60-74	656.00	576.00
75-79	683.00	599.00
80-84	711.00	624.00

Modal Factors
Direct-Billed
Annual = 1
Semi-annual = 0.515
Quarterly = 0.2625
Monthly = .1000

Modal Factors
Automatic Bank Withdrawal
Annual = 1
Semi-annual = 0.515
Quarterly = 0.2625
Monthly = .08333

Household discount - if two or more people, living in the same household at the same address, apply for coverage then each may receive a 10% premium discount.

SERFF Tracking Number:	*WAKE-126459799*	*State:*	*Arkansas*
Filing Company:	*The Order of United Commercial Travelers of America*	*State Tracking Number:*	*45063*
Company Tracking Number:	*CMMUCTDVHAR*		
TOI:	*H10I Individual Health - Dental*	*Sub-TOI:*	*H10I.000 Health - Dental*
Product Name:	*DVH Insurance*		
Project Name/Number:	*UCT/CMMUCTDVHAR*		

Supporting Document Schedules

		Item Status:	**Status Date:**
Satisfied - Item:	Flesch Certification	Approved-Closed	03/08/2010

Comments:

Attachments:

CONS NOT.pdf
Readability AR.pdf
AR - R&R19 Cert H.pdf
AR - R&R49 Cert H.pdf

		Item Status:	**Status Date:**
Satisfied - Item:	Application	Approved-Closed	03/08/2010

Comments:

Attachment:

DVH APP 0110 AR.pdf

		Item Status:	**Status Date:**
Satisfied - Item:	Outline of Coverage	Approved-Closed	03/08/2010

Comments:

Attachment:

DVH OC 0210.pdf

		Item Status:	**Status Date:**
Satisfied - Item:	Letter of Authorization	Approved-Closed	03/08/2010

Comments:

Attachment:

Auth1-15-10.pdf

Consumer Notice
The Order of United Commercial Travelers of America

Policyholder Service Office:	**1801 Watermark Drive, Suite 100** **Columbus, Ohio 43215-8619**
Telephone Number:	**800-848-0123**
Name of Agent:	**[Fred Smith]**
Agent Address:	**[123 First Street, Any Town, Arkansas]**
Agent Telephone Number:	**[555-555-1234]**

If we at The Order of United Commercial Travelers of America fail to provide you with reasonable and adequate service, you should feel free to contact:

Arkansas Insurance Department
Consumer Services Division
1200 West Third Street
Little Rock, Arkansas 72201-1904
1-800-852-5494 or 1-501-371-2460

READABILITY COMPLIANCE CERTIFICATION

Name and Address of Insurer:

The Order of United Commercial Travelers of America
1801 Watermark Drive, Suite 100
Columbus, Ohio 43215

I hereby certify that the Flesch Reading Ease Test Score of the listed forms are as follows:

Type and/or Title of Form(s)	Form Number(s)	Flesch Score
Dental Vision Hearing Expense Insurance Policy	DVH 0210	41.4
Hearing Outline of Coverage	DVH 0210 OC	43.4
Application	DVH APP 0110 AR	40.8

The type size of the text is at least 10-pointed leaded.

I also certify to the best of my knowledge and belief that the form is in compliance with the Insurance Code and with all other applicable requirements of the Insurance Department in this state.

Signature

Joseph H. Hoffman
Name

Chief Executive Officer
Title

ARKANSAS
Rule and Regulation 19 Certification

Title of Form(s)	Form Number
Dental Vision Hearing Expense Insurance Policy	DVH 0210
Hearing Outline of Coverage	DVH 0210 OC
Application	DVH APP 0110 AR

I hereby certify that the above noted forms meet the provisions of Rule and Regulation 19, the Unfair Sex Discrimination in the Sale of Insurance.

Signature

Joseph H. Hoffman
Name

Chief Executive Officer
Title

ARKANSAS
Rule and Regulation 49 Certification

Title of Form(s)	Form Number
Dental Vision Hearing Expense Insurance Policy	DVH 0210
Hearing Outline of Coverage	DVH 0210 OC
Application	DVH APP 0110 AR

I hereby certify that the above noted forms meet the provisions of Rule and Regulation 49, the Life & Health Guaranty Association Notice.

Signature

Joseph H. Hoffman

Name

Chief Executive Officer

Title

The Order of UNITED COMMERCIAL TRAVELERS OF AMERICA
Home Office: 1801 Watermark Drive, Suite 100, P.O. Box 159019, Columbus, Ohio 43215-8619
(614) 487-9680, Toll-free: (800) 848-0123, Fax: (614) 487-9675 www.uct.org

APPLICATION FOR DENTAL, VISION AND HEARING INSURANCE POLICY

Requested Effective Date of Policy

APPLICANT

Last *First* *MI*

AGE	DATE OF BIRTH			SEX
	Month	*Day*	*Year*	☐ Male ☐ Female

SOCIAL SECURITY NUMBER

APPLICANT'S ADDRESS

Street: _____

_____

_____

City: _____

State: _____ *Zip Code:* _____

Area Code: _____ *Telephone Number:* _____

*Email Address:*_____

Are you a member of The Order of United Commercial Travelers of America? ☐ **Yes** ☐ **No**

Council Name:_____ **Council Location (City & State)** _____

PLEASE SELECT THE METHOD OF PAYMENT YOU WANT

☐ Annual ☐ Semi-Annual ☐ Quarterly ☐ Monthly EFT

Amount Received with Application $_____

MEDICAL INFORMATION

		APPLICANT	
1.	Do you currently wear dentures?	☐ Yes	☐ No
2.	Have you been advised to have any dental work which has not been completed? If "Yes", provide details: _____	☐ Yes	☐ No
3.	Do you currently wear eyeglasses or contact lens?	☐ Yes	☐ No
4.	Have you received advice or treatment within the past nine (9) months for correction of a vision problem? If "Yes", provide details: _____	☐ Yes	☐ No
5.	Do you currently wear a hearing aid?	☐ Yes	☐ No
6.	Have you been treated for hearing loss within the past nine (9) months?	☐ Yes	☐ No
7.	Has a physician recommended the purchase of a hearing aid to correct a hearing deficiency?	☐ Yes	☐ No

BENEFIT OPTIONS

Policy Year Maximum	☐ **$750**	☐ **$1,000**	☐ **$1,500**	☐ **$2,000**
Deductible Options	☐ **$0**		☐ **$100**	

REPLACEMENT INFORMATION (MUST BE COMPLETED)

		APPLICANT	
1.	Do you have any dental, vision or hearing insurance currently in force?	☐ Yes	☐ No
2.	Is the insurance applied for intended to replace any existing insurance with this or any other company?	☐ Yes	☐ No

If "Yes", with which company: (Name and address): _____

_____

Policy Number: _____ If that policy lapsed, when did it lapse? _____

3. If replacement is involved, have you received a replacement form (in states where required by law)? ☐ Yes ☐ No

AUTHORIZATION
MUST BE COMPLETED AND SIGNED

WARNING: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for Insurance is guilty of a crime and may be subject to fines and confinement in prison.

_____ _____

Signature of Applicant **Date**

REASON FOR DISCLOSURE

I understand that the information requested is necessary for evaluation of my application and underwriting of my application for the Insurance Policy for which I have applied; to determine eligibility for insurance, risk rating or policy issuance determinations; obtain reinsurance, administer claims and determine or fulfill responsibility for coverage and provision of benefits; and to conduct other legally permissible activities that relate to any coverage I have, or have applied for, with The Order of United Commercial Travelers of America (UCT). I understand that failure to provide the authorization to The Order of United Commercial Travelers of America (UCT) *will* result in the rejection of the Insurance Policy coverage. I understand that I may revoke this authorization at any time by notifying The Order of United Commercial Travelers of America (UCT) in writing at their Home Office: 1801 Watermark Drive, Suite 100, P.O. Box 159019, Columbus, Ohio 43215-8619. I understand that such revocation will not have any effect on actions The Order of United Commercial Travelers of America (UCT) took prior to their receiving the revocation notice. I understand that this authorization will be valid for twenty-four (24) months from the date signed if used in connection with an application for an insurance policy, reinstatement of an insurance policy, change in policy benefits; or for the duration of a claim if used for the purpose of collecting information with a claim for benefits under the policy. A photocopy of this authorization will be treated in the same manner as the original.

_____ _____

Signature of Applicant **Date**

APPLICATION AGREEMENT

I hereby apply to The Order of United Commercial Travelers of America (UCT) for a policy to be issued in reliance on my written answers to the questions on this application. The answers are, to the best of my knowledge and belief, true. I understand that any change in my health prior to delivery of this policy may be used in the underwriting evaluation process. I have received an outline of coverage for the policy applied for.

If not a current member of The Order of United Commercial Travelers of America, I apply to become a member as indicated by my signature below. I understand UCT is a fraternal benefit society and agree to abide by the Society's Constitution and Bylaws.

_____ _____

Signature of Applicant **Date**

AGENT'S CERTIFICATION

The undersigned Agent certifies that the Applicant has read, or has had read to them, the completed application and that the Applicant realizes that any false statement or misrepresentation in the application may result in loss of coverage under the policy.

TO BE COMPLETED BY AGENT (Attach separate sheet, if necessary)

1. List any other health insurance policy you have sold to the Applicant that is still in force.

_____
_____
_____
_____

2. List any other health insurance policy you have sold to the Applicant in the past five (5) years that is no longer in force.

_____
_____
_____
_____

I certify that:

1. I have accurately recorded the information supplied by the Applicant; and
2. I have given an outline of coverage for the policy applied for to the Applicant.

Agent's Signature	**Date**
Agent's Printed Name	**Agent No.**
Agent Email:	

AUTHORITY TO HONOR PREMIUM CHECKS - ATTACH VOIDED CHECK
Deposit Slips NOT Accepted

AUTHORIZATION

IN FAVOR OF: **The Order of United Commercial Travelers of America**
1801 Watermark Drive, Suite 100, Box 159019, Columbus, Ohio 43215-8619.

Name of Bank Customer:

Insured's Name: _____

Account Number: _____ **Routing Number:** _____

To (Name of Bank): _____
Address of Bank:

You are hereby authorized, as a convenience to me, to honor and charge my account for checks, drafts and other orders, including without limitation any order initiated by electronic means, drawn by The Order of United Commercial Travelers of America indicated above, on my account by and payable to the order of The Order of United Commercial Travelers of America for the payment of premiums provided there are sufficient collected funds in such account to pay the same upon presentation. I agree that your rights in respect to each such check or other order drawn by The Order of United Commercial Travelers of America shall be the same as if it were a check drawn on you and signed personally by me. This authority is to remain in effect until revoked by me in writing, and until you actually receive such notice I agree that you shall be fully protected in honoring any such check or other orders drawn by The Order of United Commercial Travelers of America. I further agree that if any such checks or other orders drawn by The Order of United Commercial Travelers of America be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in forfeiture of insurance.

Date	**Signature of Bank Customer**

AUTHORIZATION

Signature must be the same as on the signature card at bank, and if a company account the name of the account must be shown.

To: Bank above:

In consideration of your compliance with the individual authorization of your depositors to pay checks, drafts or orders, drawn and signed by us to our Order, we agree:

- To indemnify you and hold you harmless from any loss you may suffer as a consequence of your actions resulting from or in connection with the execution and issuance of any check, draft or order, whether or not genuine, purporting to be executed and received by you in the regular course of business for the purpose of payment of such insurance premiums including any costs or expenses reasonably incurred in connection therewith.
- In the event that any such check, draft or order shall be dishonored, whether with or without cause, and whether intentionally or inadvertently, to indemnify you for such loss even though dishonor results in forfeiture of the insurance.
- To defend at our own cost and expense any action which might be brought by any depositor or any other persons because of your actions taken pursuant to said authorization and direction or in any manner arising by reason of your participation in this plan of premium collection.

THE ORDER OF
UNITED COMMERCIAL TRAVELERS OF AMERICA
1801 WATERMARK DRIVE, SUITE 100, P.O. BOX 159019, COLUMBUS, OH 43215-8619
(614) 487-9680 • TOLL-FREE: (800) 848-0123 • FAX: (614) 487-9675 • www.uct.org

DENTAL, VISION AND HEARING EXPENSE INSURANCE POLICY

THIS IS A LIMITED BENEFIT POLICY WHICH ONLY PROVIDES BENEFITS FOR DENTAL, VISION AND HEARING EXPENSES. IT DOES NOT PROVIDE BENEFITS FOR ANY OTHER SICKNESS, CONDITION OR INCAPACITY. THIS POLICY WILL NOT COVER ALL OF YOUR MEDICAL EXPENSES.

OUTLINE OF COVERAGE POLICY FORM DVH 0210

THE POLICY IS NOT A MEDICARE SUPPLEMENT POLICY. If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from the Company.

READ YOUR POLICY CAREFULLY. This outline of coverage provides a very brief description of some of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth, in detail, the rights and obligations of both you and United Commercial Travelers of America. It is therefore important that you **READ YOUR POLICY CAREFULLY.**

Dental, Vision and Hearing only coverage is designed to provide you with coverage for certain losses for dental, vision and hearing **ONLY**, subject to any limitations contained in the policy. Coverage is not provided for basic hospital, basic medical-surgical, or major medical expenses.

BENEFITS. After the Policy Year Deductible is satisfied, the following percentages of actual charges, not to exceed Reasonable and Customary Charges for Covered Expenses up to the Policy Year Maximum Benefit:

1. 60% in the first Policy Year;
2. 70% in the second Policy Year;
3. 80% in the third Policy Year; and
4. 90% thereafter.

Dental Benefits
We will pay the applicable percentage for dental services performed by a licensed Dentist, including one annual examination and cleaning, x-rays, fillings, prophylaxis, bridges, crowns, dentures and outpatient dental surgery prescribed as Medically Necessary.

After the Policy has been in force three (3) months, the Company will pay the cost of one (1) dental cleaning up to a maximum benefit of $75 each Policy Year. This benefit is not subject to the Policy Year Deductible; however, it is included in the Policy Year Maximum Benefit.

We will NOT pay any benefits during the first six (6) months following the Policy Effective Date for root canals.

We will NOT pay benefits during the first Policy Year for the following items and/or services:
Bridges, crowns, full dentures or partials, any work relating to replacement of natural teeth which were missing on the Policy Effective Date, “full mouth” extractions or fluoride treatments;

Hearing Benefits
We will pay the applicable percentage for hearing examinations performed by a Physician or Audiologist, including the cost of the hearing aid and any necessary repairs.

Vision Benefits
We will pay the applicable percentage for visits to a Physician for a basic eye examination or eye refraction, including the cost of eyeglasses or contact lenses prescribed by the Physician, up to a maximum benefit of $150 in any one (1) Policy Year.

We will NOT pay any benefits during the first six (6) months following the Policy Effective Date for existing eyeglasses or contact lens (including the renewal or changing of prescriptions).

Limitations and Exclusions

This Policy has a Policy Year Deductible as shown on the Policy Schedule Page. Once the Policy Year Deductible has been met, benefits are limited to the Policy Year Maximum Benefit as shown on the Policy Schedule Page.

We will NOT pay benefits for:

1. any loss resulting from war, declared or undeclared; or
2. any intentionally self-inflicted Injury; or
3. any loss resulting from the commission of or the attempt to commit an assault or felony; or
4. any loss resulting from engaging in any illegal activity or occupation; or
5. any services that are not recommended by a Physician or other licensed medical professional; or
6. any Experimental or Investigational Procedure or Treatment; or
7. orthodontic treatment; or
8. any expenses incurred for the diagnosis or treatment of temporomandibular joint disorder (TMJ); or
9. expenses incurred for surgical procedures (other than outpatient dental surgery) performed on an inpatient or outpatient basis (including any surgical procedure performed for the treatment of cataracts); or
10. charges for radial keratotomy (RK), automated lamellar keratoplasty (ALK), conductive keratoplasty (CK) or other cosmetic procedures; or
11. prescription drugs; or
12. charges in excess of Reasonable and Customary Charges; or
13. treatment or diagnosis received while outside the United States of America or its territories; or
14. services for which you are not liable or for which no charge normally is made in the absence of insurance; or
15. loss that occurs while this Policy is not in force.

RENEWABILITY. The policy is guaranteed renewable for life. We will renew the policy each time you send us a premium. It must be paid on or before the date it is due or during the 31 days that follow.

PREMIUM CHANGE. We may change the premium rates for the policy. The change will be based on a new table of rates. We can only change the premium if we change it for all policies like yours in your class and in the same state where your policy was issued.

THE ORDER OF
UNITED COMMERCIAL TRAVELERS OF AMERICA
1801 WATERMARK DRIVE, SUITE 100, P.O. BOX 159019, COLUMBUS, OHIO 43215-8619
(614) 487-9680 • TOLL-FREE: (800) 848-0123 • FAX: (614) 487-9675 • www.uct.org

January 15, 2010

J. Steven Keck, FSA, MAAA
Wakely Actuarial Services, Inc.
34125 US Highway 19 North, Suite 310
Palm Harbor, FL 34684

Dear Mr. Keck:

The firm of Wakely Actuarial Services, Inc. is hereby authorized to submit form filings for approval to the Department of Insurance on behalf of The Order of United Commercial Travelers of America. Changes to the forms, as may be necessary to gain approval, are included in this authorization.

Thank you.

Sincerely,

Joseph Hoffman
Chief Executive Officer

SERFF Tracking Number:	*WAKE-126459799*	*State:*	*Arkansas*
Filing Company:	*The Order of United Commercial Travelers of America*	*State Tracking Number:*	*45063*
Company Tracking Number:	*CMMUCTDVHAR*		
TOI:	*H10I Individual Health - Dental*	*Sub-TOI:*	*H10I.000 Health - Dental*
Product Name:	*DVH Insurance*		
Project Name/Number:	*UCT/CMMUCTDVHAR*		

Superseded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Creation Date:	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
02/27/2010	Form	Dental Vision and Hearing Policy	03/05/2010	DVH 0210.pdf (Superceded)
03/01/2010	Form	Outline of Coverage	03/05/2010	DVH OC 0210.pdf (Superceded)

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DENTAL, VISION AND HEARING EXPENSE INSURANCE POLICY

THIS IS A LIMITED BENEFIT POLICY WHICH ONLY PROVIDES BENEFITS FOR DENTAL, VISION AND HEARING EXPENSES. IT DOES NOT PROVIDE BENEFITS FOR ANY OTHER SICKNESS, CONDITION OR INCAPACITY. THIS POLICY WILL NOT COVER ALL OF YOUR MEDICAL EXPENSES.

THIS IS A LEGAL CONTRACT BETWEEN THE OWNER AND US.

This is a contract between You and The Order of United Commercial Travelers of America (UCT). We issue this Policy based on the application signed by You and the payment of premiums as stated on the Policy Schedule Page. We will pay the benefits subject to all the terms and conditions of this Policy. This Policy begins on the Date of Issue listed on the Policy Schedule Page. Payment of each premium as it comes due will continue coverage to the next premium due date.

The Order of United Commercial Travelers of America will pay the benefits of this Policy for an Insured Loss subject to the provisions and limitations of the Policy.

IMPORTANT NOTICE: The issuance of this Policy is based on the Insured's answers to the questions on the application. A copy of the application is attached. Omissions or misstatements on the application could cause a claim to be denied or the Policy to be rescinded. If, for any reason the answers are incorrect, contact Us immediately at Our Home Office in Columbus, Ohio.

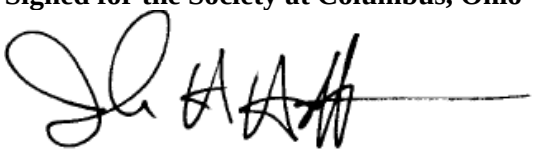
Thirty Day Right To Examine and Return Policy

Please read this Policy carefully. If, for any reason You are not satisfied, the Policy may be returned to Us within thirty (30) days after receiving it. If returned, the Policy will be void from its beginning and any premium paid will be refunded.

Guaranteed Renewable for Life - Premium Subject to Change

This Policy is renewable as long as You live, provided You continue to pay premiums when due. At no time while You continue Your Policy in force, may We place any restrictive riders on Your coverage. The premium may change if a new table of rates is applicable to the Policy. The change in the table of rates will apply to all covered persons in the same class on the date of the change. Class is defined as underwriting class, state and zip code of residence. You will be notified at least thirty (30) days prior to any change in the table of rates becoming effective.

Signed for the Society at Columbus, Ohio



Chief Executive Officer

NOTICE TO BUYER: This is NOT a Medicare Supplement Policy. If You are eligible for Medicare, review the Medicare Supplement Buyer's Guide available from Us.

NON-PARTICIPATING

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Application ..... **Attached**

POLICY SCHEDULE PAGE

Policy Number: **[12345678]** **Policy Effective Date:** **[July 1, 2010]**

Policyholder Name: **[John Doe]** **Issue Age:** **[45]**

Mode At Issue: **Modal Premium:**

****

Policy Year Deductible: **[$0 or $100]**

Policy Year Maximum Benefit: **[$750, $1,000, $1,500 or $2,000]**

Definitions

Audiologist refers to a person duly licensed and legally entitled to practice audiology at the time and in the state or jurisdiction in which services are performed, other than a member of the Insured's Immediate Family.

Covered Expense or Covered Loss refers to expenses incurred for Medically Necessary medical and dental services or supplies prescribed by a licensed medical professional. Covered Expenses may not be more than the Reasonable and Customary Charges for such services or supplies and will be deemed to be incurred on the date or dates such services or supplies are received by the Insured. Covered Expenses must be incurred while this Policy is in force.

Dentist refers to a person duly licensed and legally entitled to practice dentistry at the time and in the state or jurisdiction in which services are performed, other than a member of the Insured's Immediate Family.

Experimental or Investigational Procedure or Treatment refers to the use of a treatment (drugs, devices and/or procedures) for a specific condition when all of the following are true:

1. the safety and effectiveness of a device is not proven; i.e. pre-market approval has not been granted (devices only);
2. benefits to at least one-third (1/3) of subjects are not documented in controlled clinical trials published in peer-reviewed English language medical journals; and
3. the treatment is not generally accepted medical practice as determined by review of peer-reviewed English language medical literature or authoritative medical journals or publications.

Immediate Family means Your spouse; parents; grandparents; children; or siblings and their spouses.

Injury means a bodily Injury which is the direct result of an accident and independent of all other causes that occurs after the Policy Effective Date and while this Policy is in force.

Insured refers to the person who is insured under this Policy. The Insured is as named in the application and shown on the Policy Schedule Page.

Medically Necessary means a service or supply that is required to diagnose or treat an Injury or Sickness and is:

1. prescribed by a Physician or other licensed medical professional;
2. consistent with the diagnosis and treatment of the Injury or Sickness;
3. in accordance with the generally accepted standards of medical practice; and
4. not solely for the convenience of You or the Physician or other licensed medical professional.

Ophthalmologist is a Physician duly licensed and legally entitled to practice ophthalmology at the time and in the state or jurisdiction in which services are performed, other than a member of the Insured's Immediate Family.

Optometrist is a Physician duly licensed and legally entitled to practice optometry at the time and in the state or jurisdiction in which services were performed, other than a member of the Insured's Immediate Family.

Physician means any practitioner of the healing arts acting within the scope of his/her license, other than a member of the Insured's Immediate Family.

Policy Effective Date is the effective date of this Policy and is as shown on the Policy Schedule Page. The Policy Effective Date is not the date the application for coverage was signed.

Policy Year is a period of twelve months beginning each year on the month and day of the Policy Effective Date.

Policy Year Deductible refers to the dollar amount for which You are responsible during each Policy Year as shown on the Policy Schedule Page.

Definitions Continued

Policy Year Maximum Benefit is the maximum amount We will pay during any Policy Year as shown on the Policy Schedule Page.

Pre-Existing Condition means a condition for which symptoms existed prior to the Policy Effective Date that would cause an ordinarily prudent person to seek diagnosis, care or treatment or for which medical advice or treatment was recommended by a Physician or received from a Physician.

Reasonable and Customary Charge refers to the normal and prevailing charge, fee, or expense for the service rendered or for the material furnished in the geographic area where rendered or furnished.

Sickness means illness or disease with first manifests itself after the Policy Effective Date and while this Policy is in force.

Written Notice to the Company means a request in writing on forms furnished by or acceptable to the Company. All correspondence should be sent to Our Home Office at P.O. Box 159019, Columbus, Ohio 43215.

We, Our, Us, Society, Company, UCT means The Order of United Commercial Travelers of America.

You, Your, Yours means the Insured named on the Policy Schedule Page.

Benefit Provisions

After the Policy Year Deductible is satisfied, the Company will pay the following percentages of actual charges, not to exceed Reasonable and Customary Charges for Covered Expenses up to the Policy Year Maximum Benefit:

1. 60% in the first Policy Year;
2. 70% in the second Policy Year;
3. 80% in the third Policy Year; and
4. 90% thereafter.

Covered Expenses, subject to the Limitations and Exclusions, are:

Dental Benefits
We will pay the applicable percentage for dental services performed by a licensed Dentist, including one annual examination and cleaning, x-rays, fillings, prophylaxis, bridges, crowns, dentures and outpatient dental surgery prescribed as Medically Necessary.

After the Policy has been in force three (3) months, the Company will pay the cost of one (1) dental cleaning up to a maximum benefit of $75 each Policy Year. This benefit is not subject to the Policy Year Deductible; however, it is included in the Policy Year Maximum Benefit.

We will NOT pay any benefits during the first six (6) months following the Policy Effective Date for root canals.

We will NOT pay benefits during the first Policy Year for the following items and/or services:
Bridges, crowns, full dentures or partials, any work relating to replacement of natural teeth which were missing on the Policy Effective Date, “full mouth” extractions or fluoride treatments;

Hearing Benefits
We will pay the applicable percentage for hearing examinations performed by a Physician or Audiologist, including the cost of the hearing aid and any necessary repairs.

We will NOT pay benefits during the first Policy Year for existing hearing aids.

Benefit Provisions Continued

Vision Benefits
We will pay the applicable percentage for visits to a Physician for a basic eye examination or eye refraction, including the cost of eyeglasses or contact lenses prescribed by the Physician, up to a maximum benefit of $150 in any one (1) Policy Year.

We will NOT pay any benefits during the first six (6) months following the Policy Effective Date for existing eyeglasses or contact lens (including the renewal or changing of prescriptions).

Limitations and Exclusions

This Policy has a Policy Year Deductible as shown on the Policy Schedule Page. Once the Policy Year Deductible has been met, benefits are limited to the Policy Year Maximum Benefit as shown on the Policy Schedule Page.

We will NOT pay benefits for:

1. any loss resulting from war, declared or undeclared; or
2. any intentionally self-inflicted Injury; or
3. any loss resulting from the commission of or the attempt to commit an assault or felony; or
4. any loss resulting from engaging in any illegal activity or occupation; or
5. any services that are not recommended by a Physician or other licensed medical professional; or
6. any Experimental or Investigational Procedure or Treatment; or
7. orthodontic treatment; or
8. any expenses incurred for the diagnosis or treatment of temporomandibular joint disorder (TMJ); or
9. expenses incurred for surgical procedures (other than outpatient dental surgery) performed on an inpatient or outpatient basis (including any surgical procedure performed for the treatment of cataracts); or
10. charges for radial keratotomy (RK), automated lamellar keratoplasty (ALK), conductive keratoplasty (CK) or other cosmetic procedures; or
11. prescription drugs; or
12. charges in excess of Reasonable and Customary Charges; or
13. treatment or diagnosis received while outside the United States of America or its territories; or
14. services for which you are not liable or for which no charge normally is made in the absence of insurance; or
15. loss that occurs while this Policy is not in force.

General Provisions

Entire Contract; Changes – This Policy, including the application, endorsements and attached documents, if any, constitutes the entire contract of insurance. No change in this Policy shall be valid unless approved by one of the Company's officers and unless such approval shall be endorsed hereon or attached hereto. No agent or officer of any Local, Grand or Supreme Council has authority to change this Policy or to waive any of its provisions.

Time Limit On Certain Defenses (Contestable Period) – Statements in the application are considered representations, not warranties. Statements may be used to contest the validity of this Policy or in defense of a claim only if they are contained in an attached application or endorsement. The Company cannot contest this Policy after it has been in force two years during the Insured's lifetime, from the Policy Effective Date.

Grace Period – A Grace Period of thirty-one (31) days will be granted for the payment of each premium falling due after the first premium. This Policy shall continue in force during any Grace Period.

Reinstatement – If any renewal premium is not paid within the time granted by Us for payment, a subsequent acceptance of any premium by Us or by any of Our authorized agents, without requiring an application for reinstatement, shall reinstate the Policy; provided, however that, if We or any of Our authorized agents require an application for reinstatement and issues a conditional receipt for the premium tendered, the Policy will be reinstated upon approval of such application by Us or, lacking such approval, upon the forty-fifth (45) day following the date of such conditional receipt unless We have previously notified You in writing of Our disapproval of such application. The reinstated Policy shall cover only loss resulting from any accidental Injury as may be sustained after the date of reinstatement and loss due to any Sickness as may begin more than ten (10) days after that date. In all other respects, We and You shall have the same rights there under as We and You had under the Policy immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with reinstatement.

Notice of Claim – We must receive written Notice of Claim within twenty (20) days after any Covered Loss occurs or begins. If notice cannot be given at that time, it must be given as soon as reasonably possible. Notice given by or on Your behalf to the Society at Our Home Office at 1801 Watermark Drive, Suite 100, P.O. Box 159019, Columbus, Ohio 43215-8619, or to any authorized agent of Us, with information sufficient to identify You, shall be deemed notice to Us.

Claim Forms – When We get a Notice of Claim, We will send You forms for filing Proof of Loss. If We do not send the forms within fifteen (15) working days after receiving Written Notice, Our requirements will be met if We receive written proof of the event and type and extent of the loss within ninety (90) days after the date the loss began or occurred.

Proof of Loss – We must receive written Proof of Loss within ninety (90) days after the date the loss began or occurred. If it is not reasonably possible to give this timely proof, the claim will not be affected if it is sent as soon as is reasonable. However, unless the Insured making the claim is legally incapacitated, proof must be given within one (1) year from the time it is otherwise due.

Time of Payment of Claims – All benefits payable under this Policy will be payable immediately upon receipt of due Proof of Loss.

If We do not pay benefits upon receipt of due Proof of Loss, We shall have fifteen (15) working days to mail to You a letter or notice which states the reasons We have for not paying the claim, either in whole or in part, including an itemization of any documents or other information needed to process the claim or any portions thereof which have not been paid. Once all of the listed documents or other information needed to process the claim have been received, We shall then have fifteen (15) working days to process and either pay the claim or deny it, in whole or in part, giving You the reasons We may have for denying such claim or any portion thereof.

Payment of Claims – We will pay all benefits to You; benefits under this Policy are not subject to assignment. Any benefits unpaid at Your death will be paid to Your estate or Your designated beneficiary.

Legal Actions – No action at law or in equity shall be brought to recover on this Policy prior to the expiration of sixty (60) days after written Proof of Loss has been furnished in accordance with the requirements of this Policy. No such action shall be brought after the expiration of three (3) years after the time written Proof of Loss is required to be furnished.

Misstatement Of Age or Sex – If the Insured's age or sex has been misstated, all amounts payable under this Policy shall be such as the premium paid would have purchased at the correct age and sex.

Unpaid Premium: Upon the payment of a claim under this Policy, any premium then due and unpaid or covered by any note or written order may be deducted therefrom.

Pro Rata Refund: If We receive written proof of death which terminates coverage, We will refund that part of any premium You have paid which covers a period after death occurs.

Cancellation By Insured – You may cancel this Policy at any time by Written Notice to the Company delivered or mailed to Us. Cancellation will be effective upon receipt of the Written Notice or on a later date as specified in the notice. In the event of cancellation of this Policy, We shall make a pro-rata refund of any premium paid beyond the date of cancellation. Cancellation shall be without prejudice to any claim originating prior to the date of the cancellation.

Insurance coverage will terminate automatically as of the premium due date if premium for this Policy is in default beyond the end of the Grace Period.

Conformity With State Statute – Any provision of the Policy which, on the Policy Effective Date, is in conflict with the laws of the state in which the Insured resides on such date is hereby amended to conform to the minimum requirements of such statutes.

Clerical Error – Clerical error on Our part will not invalidate insurance otherwise in force nor continue insurance otherwise terminated. Upon discovery of any error, an equitable adjustment will be made in the premiums. Complete proof documenting any clerical errors must be supplied.

Owner – The Insured is the Owner of this Policy and may exercise all options and rights under this Policy.

Maintenance of Solvency – UCT's constitution provides that in the event that its reserves as to all or any class of contracts of insurance issued by it become impaired, the Board of Governors may require that these shall be paid by each Owner of such contract of insurance to UCT an amount equal to such Owner's equitable portion of such deficiency as ascertained by the Board of Governors.

If payment of the amount required is not made by such Owner, then either or both of the following, at the election of the Owner, shall apply:

1. the amount shall stand as Indebtedness against the contract of insurance and shall bear interest at a rate not to exceed ten percent (10%) per annum; or
2. the Owner shall accept a proportionate reduction in benefits paid pursuant to the contract of insurance.

The Owner shall make such election by notifying the Board of Governors of his or her election on a form prescribed by the Board of Governors that shall be provided to each Owner. Failure to make such election shall result in a presumption that the Owner elects to accept a proportionate reduction in benefits paid pursuant to the contract of insurance.

The Owner hereby agrees that if they affirmatively elect to have the amount stand as Indebtedness against the contract of insurance, then UCT may offset the amount of such Indebtedness together with interest thereon against any payment of benefits under this contract of insurance.

Suspension or Expulsion – If the Insured should be expelled or suspended from the membership in the Society for any reason, except nonpayment of premium or within the Contestable Period for misrepresentation on the Insured's application for membership, the Insured shall have the privilege of maintaining this Policy in force by continuing payment of the required premium.

DENTAL, VISION AND HEARING EXPENSE POLICY
A LIMITED BENEFIT INSURANCE POLICY

NON-PARTICIPATING

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3. any loss resulting from the commission of or the attempt to commit an assault or felony; or
4. any loss resulting from engaging in any illegal activity or occupation; or
5. any services that are not recommended by a Physician or other licensed medical professional; or
6. any Experimental or Investigational Procedure or Treatment; or
7. orthodontic treatment; or
8. any expenses incurred for the diagnosis or treatment of temporomandibular joint disorder (TMJ); or
9. expenses incurred for surgical procedures (other than outpatient dental surgery) performed on an inpatient or outpatient basis (including any surgical procedure performed for the treatment of cataracts); or
10. charges for radial keratotomy (RK), automated lamellar keratoplasty (ALK), conductive keratoplasty (CK) or other cosmetic procedures; or
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13. treatment or diagnosis received while outside the United States of America or its territories; or
14. services for which you are not liable or for which no charge normally is made in the absence of insurance; or
15. loss that occurs while this Policy is not in force.

RENEWABILITY. The policy is guaranteed renewable for life. We will renew the policy each time you send us a premium. It must be paid on or before the date it is due or during the 31 days that follow.

PREMIUM CHANGE. We may change the premium rates for the policy. The change will be based on a new table of rates. We can only change the premium if we change it for all policies like yours in your class and in the same state where your policy was issued.